INITIAL PARENT QUESTIONNAIRE: Behavioral Health and Learning Evaluation.
Part 1: Child Health

Child's Name (Last, First): Date of Birth: Age: Today's Date:

Child's Social Security Number: -- -- Child's Sex: M F

Address: City: State: Zip: Phone:

Child's Doctor: Doctor's Phone:

Name of person completing this form: Relationship to child: Phone:

CHIEF CONCERN:

1. **Who** suggested this child be seen by the doctor for attention, school, or behavior problems?

2. What **concerns** do you have about this child?
a.

b.

c.

3. **How long** have you been concerned about this child's behavior?	4. Please circle ONE: Overall, the above concerns are **mild**, **moderate**, or **severe**?	5. Please circle ONE: My concerns are **improving**, **staying the same**, or **getting worse**?

6. Please describe this child's **strongest areas at home**:	7. Please describe this child's **weakest areas at home**:
a.	a.
b.	b.
c.	c.

HISTORY: Birth

1. How much did this child weigh at birth? ___pounds ___ounces

2. Biological **Father's age** at birth of this child:_____

3. Biological **Mother's age** at birth of this child:_____

4. Number of **pregnancies prior** to this child:_____

5. Number of **miscarriages prior** to this child:_____

Y	N	
Y	N	6. Were there any **problems during the pregnancy**? Specify:
Y	N	7. Were there any **problems during labor / delivery** or **following the birth**? Specify:
Y	N	8. Was this child born by **Cesarean / C-Section**? If yes, circle appropriate response: **planned** **emergency**
Y	N	9. Was this child born **two or more weeks before** the "due date"? If yes, how many weeks early was this child? _____ weeks
Y	N	10. Were any substances or medications used by the mother during the pregnancy? _____Beer / Wine _____Alcohol _____Any prescription medication _____Cocaine _____Tobacco _____Marijuana _____Methamphetamine (Crystal / Ice) _____Other:_____
Y	N	11. Were any substances or medications used by the father around the time this child was conceived? _____Beer / Wine _____Alcohol _____Any prescription medication _____Cocaine _____Tobacco _____Marijuana _____Methamphetamine (Crystal / Ice) _____Other:_____

HISTORY: Developmental Concerns

1. Did this child **sit up** by 8 months?	**Y**	**N**
2. Did this child **crawl** by 10 months?	**Y**	**N**
3. Did this child **walk** by 15 months?	**Y**	**N**
4. Did this child **speak 2 word sentences** by 2 years?	**Y**	**N**
5. Could strangers **understand** this child by 3 years?	**Y**	**N**
6. Did this child **stay dry during the day** by 3 ½ years?	**Y**	**N**
7. Did this child **read simple words** by 6 years?	**Y**	**N**

Medical Provider Use ONLY Concerns present over 6 months: Y N Pregnancy, labor, delivery concerns: Y N Developmental Concerns: Y N

INITIAL PARENT QUESTIONNAIRE: Behavioral Health and Learning Evaluation.
Part 1: Child Health (continued)

Child's Name & last 4 of [Sponsor's] Social:

HISTORY: Behavioral		
Y	**N**	1. Did this child **cry frequently** as an infant?
Y	**N**	2. Was this child **difficult to calm** down as an infant?
Y	**N**	3. Did this child **have trouble sleeping** as an infant (e.g., was this child fidgety or overly sleepy)?
Y	**N**	4. Was this child a **picky or irregular eater** as an infant?
Y	**N**	5. Did this child have **many temper tantrums** as a toddler?
Y	**N**	6. Did you have **trouble keeping a babysitter** because of this child's behavior?
Y	**N**	7. Does this child have **urine accidents**?
Y	**N**	8. Does this child have **stool / bowel accidents**?
Y	**N**	9. Does this child often have **nightmares**?
Y	**N**	10. Has this child ever had **tics or nervous twitches**, such as repeated eye blinking, head jerking, or throat clearing?
Y	**N**	11. Does this child have any **problems falling asleep**? Specify:
Y	**N**	12. Does this child have any **problems staying asleep** through the night? Specify:
Y	**N**	13. Does this child have any **problems getting up** in the morning? Specify:
Y	**N**	14. Does this child have **frequent stomachaches and headaches**? Specify:
Y	**N**	15. Does this child have **problems with his/her weight**? Specify:

HISTORY: Health		
Y	**N**	1. Has this child had any **major health problems**? Specify:
Y	**N**	2. Has this child had frequent **ear infections**?
Y	**N**	3. Has this child had any **vision / eye or hearing** problems? Specify:
Y	**N**	4. Has this child ever been **hospitalized** or had **surgery**? Specify:
Y	**N**	5. Has this child lost **consciousness** or had a **serious head injury**? Specify:
Y	**N**	6. Has this child had **meningitis** or **encephalitis**? Specify:
Y	**N**	7. Has this child had **seizures**?
Y	**N**	8. Has this child had any **difficulties with growth**? Specify:
Y	**N**	9. Does this child have any **birth defects** or **birthmarks**? Specify:

HISTORY: Family Medical Problems: Is there any one in this child's family with the following:				If yes, how is this person related to this child?
Y	**N**	**Don't Know**	1. Neurologic problems	
Y	**N**	**Don't Know**	2. Learning or reading difficulty	
Y	**N**	**Don't Know**	3. Depression	
Y	**N**	**Don't Know**	4. Bipolar Disorder / Manic Depression	
Y	**N**	**Don't Know**	5. Schizophrenia	
Y	**N**	**Don't Know**	6. History of physical or sexual abuse	
Y	**N**	**Don't Know**	7. Alcohol or Drug problems	
Y	**N**	**Don't Know**	8. ADHD / ADD (attention problems)	
Y	**N**	**Don't Know**	9. Tics or Tourette's disorder	
Y	**N**	**Don't Know**	10. Trouble with the law	
Y	**N**	**Don't Know**	11. Medications for nerves or emotional problems	
Y	**N**	**Don't Know**	12. Thyroid problems	
Y	**N**	**Don't Know**	13. Exposure to toxic chemicals	

Medical Provider Use ONLY **Behavior:** Y N **Health:** Y N **Family Medical History:** Y N **[Baselines] Tics:** Y N **Sleep Problems:** Y N **Stomachache/Headache:** Y N **Weight:** Y N

INITIAL PARENT QUESTIONNAIRE: Behavioral Health and Learning Evaluation.
Part 2: Child Information

Child's Name & last 4 of [Sponsor's] Social:

HISTORY: Child's Past/Current Treatment

Y	N	
		1. Has this child **ever been diagnosed with ADHD or ADD in the past**? If yes: Year ____ Month ____
		2. Has this child **ever taken medication for ADHD or ADD in the past**? If yes, do you know the **name**, **dose,** and **time(s) of day** the medication was given?

a. **Name**	**Dose**	**Time(s) of Day**
b.		

c. Were you **satisfied** with the medication's effect on this child's symptoms? (circle) Yes No

Y	N	
		3. Has this child **ever received psychological counseling** for any problems? Specify:
		4. Has this child ever been on any **long-term medications**? Specify:
		5. Does this child have any **allergies**? Specify:
		6. Is this child currently taking any **medications?**
		7. Is this child currently taking any **vitamins or herbal supplements?**

7. **What medication(s), including vitamins or herbal supplements, is this child currently taking?**

Name	**Dose**	**Time(s) of Day**
a.		
b.		
c.		

8. **Are there any professionals (**such as doctors, nurses, psychiatrists, social workers, occupational therapists, speech therapists, physical therapists, or alternative treatments) **currently involved in this child's care? Please list them and their role in your child's care:**

HISTORY: Social

Y	N	
		1. Have there been any **major changes or stresses** in this child's life (e.g., marital problems, a move, change of school, birth of a brother or sister, a death of a pet)? If yes, please specify and include how old the child was at the time: Is this stress still occurring? (circle) Yes No
		2. Has there been a **serious illness or death** in a parent or close family member of this child? If yes, please specify and include how old the child was at the time:
		3. Has this child **experienced or seen any traumatic events** (e.g., domestic violence, physical or sexual abuse) that you would like to discuss with your doctor? If yes, please specify and include how old the child was at the time: Is this trauma still occurring? (circle) Yes No
		4. Are any **major changes or stresses** expected in the future? If yes, please specify:

Medical Provider Use ONLY **Past ADHD Diagnosis: Y N** **Past ADHD Treatment: Y N** **Medications: Y N** **Professionals: Y N** **Social: Y N**